Senate Engrossed

State of Arizona
Senate
Forty-fifth Legislature
First Regular Session
2001

CHAPTER 31

SENATE BILL 1141

AN ACT

AMENDING SECTION 36-2904, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-2904, Arizona Revised Statutes, is amended to read:

36-2904. Prepaid capitation coverage; requirements; long-term care; dispute resolution; award of contracts; notification; report

A. The administration may expend public funds appropriated for the purposes of this article and shall execute prepaid capitated health services contracts, pursuant to section 36-2906, with group disability insurers, hospital and medical service corporations, health care services organizations and any other appropriate public or private persons, including county-owned and operated facilities, for health and medical services to be provided under contract with providers. ~~Beginning October 1, 1997,~~ The administration may assign liability for eligible persons and members through contractual agreements with prepaid capitated providers. ~~In the event that~~ IF there is an insufficient number of qualified bids for prepaid capitated health services contracts for the provision of hospitalization and medical care within a county, the director may:

1. Execute discount advance payment contracts, pursuant to section 36-2906 and subject to section 36-2903.01, for hospital services.

2. Execute capped fee-for-service contracts for health and medical services, other than hospital services. Any capped fee-for-service contract shall provide for reimbursement at a level of not to exceed a capped fee-for-service schedule adopted by the administration.

B. During any period in which services are needed and no contract exists, the director may do either of the following:

1. Pay nonproviders for health and medical services, other than hospital services, on a capped fee-for-service basis for members and persons who are determined eligible. However, the state shall not pay any amount for services which exceeds a maximum amount set forth in a capped fee-for-service schedule adopted by the administration.

2. Pay a hospital subject to the reimbursement level limitation prescribed in section 36-2903.01.

If health and medical services are provided in the absence of a contract, the director shall continue to attempt to procure by the bid process as provided in section 36-2906 contracts for such services as specified in this subsection.

C. Payments to providers shall be made monthly or quarterly and may be subject to contract provisions requiring the retention of a specified percentage of the payment by the director, a reserve fund or other contract provisions by which adjustments to the payments are made based on utilization efficiency, including incentives for maintaining quality care and minimizing unnecessary inpatient services. Reserve funds withheld from provider contracts shall be distributed to providers who meet performance standards established by the director. Any reserve fund established pursuant to this

subsection shall be established as a separate account within the Arizona health care cost containment system fund.

D. In carrying out the duty to provide hospitalization and medical care to members, the administration shall adopt rules for the payment of copayments by members and, except for emergency situations, may require the payment of deductibles, coinsurance or premiums by members who are eligible pursuant to section 36-2901, paragraph 4, subdivision (a), (b), (c), (h) or (j). The administration shall also adopt rules requiring the collection by system providers of a copayment of five dollars from members eligible under section 36-2901, paragraph 4, subdivisions (a), (c), (h) and (j) for each physician's office visit or home visit and a copayment of twenty-five dollars for the nonemergency use of the emergency room except in those circumstances when a primary care physician or primary care practitioner refers the member or eligible person to an emergency room for care. These rules shall provide for the waiver of copayments in appropriate circumstances for members who are eligible pursuant to section 36-2901, paragraph 4, subdivision (b). The rules shall define the provider as the collector of copayments and the administration or the counties, on behalf of the administration, as the collector of coinsurance, deductibles and premiums. Staff in the hospital shall advise the member or eligible person that if the visit to the emergency room is not for an emergency condition, as determined by the hospital, the member or eligible person shall be charged the required copayment for the nonemergency use of the emergency room.

E. A member defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (b) may select, to the extent practicable as determined by the administration, from among the available providers of hospitalization and medical care and may select a primary care physician or primary care practitioner from among the primary care physicians and primary care practitioners participating in the contract in which the member is enrolled. The system shall only provide reimbursement for any health or medical services or costs of related services provided by or under referral from any primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific providers in the system.

F. For a member defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (a), (c) or (h) the director shall implement a policy permitting choice of provider to the extent ~~he~~ THE DIRECTOR deems feasible. If the director does not implement a choice of provider policy, ~~he may~~ THE DIRECTOR at the time eligibility is determined MAY enroll the member with an available provider located in the geographic area of the member's residence. The member may select a primary care physician or primary care practitioner from among the primary care physicians or primary care practitioners participating in the contract in which the member is enrolled. The system shall only provide reimbursement for health or medical

services or costs of related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific providers in the system.

G. If a person who has been determined eligible but who has not yet enrolled in the system receives emergency services, the director shall provide by rule for the enrollment of the person on a priority basis. If a person requires system covered services on or after the date the person is determined eligible for the system but before the date of enrollment, the person is entitled to receive ~~such~~ THESE services in accordance with rules adopted by the director, and the administration shall pay for ~~such~~ THE services pursuant to section 36-2903.01 or, as specified in contract, by the prepaid capitated provider pursuant to the subcontracted rate or this section.

H. The administration shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed OR AFTER THE DATE THAT ELIGIBILITY IS POSTED, WHICHEVER DATE IS LATER, or that are submitted as clean claims more than twelve months after the date of service for which payment is claimed OR AFTER THE DATE THAT ELIGIBILITY IS POSTED, WHICHEVER DATE IS LATER, except for claims submitted for reinsurance pursuant to section 36-2906, subsection C, paragraph 6 or services covered pursuant to subsection I of this section. The administration shall not pay claims FOR SYSTEM COVERED SERVICES that are submitted by prepaid capitated providers for reinsurance ~~and that are submitted more than twelve months after the date of service~~ AFTER THE TIME PERIOD SPECIFIED IN THE CONTRACT. ~~The administration shall not pay reinsurance claims that are submitted more than twelve months after the date of service.~~ The director may adopt rules or require contractual provisions that prescribe requirements and time limits for submittal of and payment for those claims. Notwithstanding any other provision of this article, if a claim that gives rise to a prepaid capitated provider's claim for reinsurance or deferred liability is the subject of an administrative grievance or appeal proceeding or other legal action, the prepaid capitated provider shall have at least ~~thirty-five~~ SIXTY days after an ultimate decision is rendered to submit a claim for reinsurance or deferred liability. Prepaid capitated providers that contract with the administration pursuant to subsection A of this section ~~are~~ SHALL not ~~required to~~ pay claims for system covered services that are INITIALLY submitted more than six months after the date of the service for which payment is claimed OR AFTER THE DATE THAT ELIGIBILITY IS POSTED, WHICHEVER DATE IS LATER, or that are submitted as clean claims more than twelve months after the date of the service for which payment is claimed OR AFTER THE DATE THAT ELIGIBILITY IS POSTED, WHICHEVER DATE IS LATER. ~~In the absence of a contract to the contrary, neither the administration nor prepaid capitated providers shall require subcontracting providers or~~

~~nonproviders to initially submit claims less than six months after the date of the service for which payment is claimed or to submit clean claims less than twelve months after the date of the service for which payment is claimed. A person dissatisfied with the denial of a claim by the administration or a prepaid capitated provider has twelve months from the date of the service for which payment is claimed to institute a grievance against the administration or a prepaid capitated provider pursuant to section 36-2903.01, subsection B, paragraph 4.~~ For purposes of this subsection:

1. "Clean claims" means claims that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

2. "Date of service" for a hospital inpatient means the date of discharge of the patient.

3. "SUBMITTED" MEANS THE DATE THE CLAIM IS RECEIVED BY THE ADMINISTRATION OR THE PREPAID CAPITATED PROVIDER, WHICHEVER IS APPLICABLE, AS ESTABLISHED BY THE DATE STAMP ON THE FACE OF THE DOCUMENT OR OTHER RECORD OF RECEIPT.

I. ~~In situations in which~~ IF federal law requires coverage for a person before the date of enrollment for persons eligible pursuant to section 36-2901, paragraph 4, subdivision (b), the administration shall pay for these services in accordance with federal law at the level established pursuant to subsections A and B of this section and section 36-2903.01 or the prepaid capitated provider shall pay for these services, as specified in contract, pursuant to the subcontracted rate or section 36-2904.

J. In any county having a population of five hundred thousand or fewer persons, a hospital which executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other provider providing services to that portion of the county and to any other person that plans to become a provider in that portion of the county. If such a hospital executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all providers with whom the hospital executes such a subcontract. Reimbursement levels offered by hospitals to providers pursuant to this subsection may vary among providers only as a result of the number of bed days purchased by the provider, the amount of financial deposit required by the hospital, if any, or the schedule of performance discounts offered by the hospital to the provider for timely payment of claims.

K. This subsection applies to inpatient hospital admissions and to outpatient hospital services on and after March 1, 1993. The director may negotiate at any time with a hospital on behalf of a provider for services provided pursuant to this article. If a provider negotiates with a hospital

for services provided pursuant to this article, the following procedures apply:

1. The director shall require any provider to reimburse hospitals for services provided under this article based on reimbursement levels that do not in the aggregate exceed those established pursuant to section 36-2903.01 and under terms and conditions on which the provider and the hospital agree. However, a hospital and a provider may agree on a different payment methodology than the methodology prescribed by the director pursuant to section 36-2903.01. The director by rule shall prescribe:

(a) The time limits for any negotiation between the provider and the hospital.

(b) The ability of the director to review and approve or disapprove the reimbursement levels, terms and conditions agreed on by the provider and the hospital.

(c) That if a provider and a hospital do not agree on reimbursement levels, terms and conditions as required by this subsection, the reimbursement levels established pursuant to section 36-2903.01 apply.

(d) That, except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of subdivision (f) of this paragraph ~~upon~~ ON initial receipt of the legible, error-free claim form by the provider if the claim includes the following error-free documentation in legible form:

(i) An admission face sheet.

(ii) An itemized statement.

(iii) An admission history and physical.

(iv) A discharge summary or an interim summary if the claim is split.

(v) An emergency record, if admission was through the emergency room.

(vi) Operative reports, if applicable.

(vii) A labor and delivery room report, if applicable.

(e) That payment received by a hospital from a provider is considered payment by the provider of the provider's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third party payors or in situations covered by title 33, chapter 7, article 3.

(f) That a provider shall pay for services rendered on and after October 1, 1997 under any reimbursement level according to paragraph 1 of this subsection subject to the following:

(i) Except for members who are eligible pursuant to section 36-2901, paragraph 4, subdivisions (a), (c), (h) and (j), if the hospital's bill is paid within thirty days of the date the bill was received, the provider shall pay ninety-nine per cent of the rate.

(ii) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the provider shall pay one hundred per cent of the rate.

(iii) If the hospital's bill is paid any time after sixty days of the date the bill was received, the provider shall pay one hundred per cent of

the rate plus a fee of one per cent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

2. In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other provider providing services to that portion of the county and to any other person that plans to become a provider in that portion of the county. If a hospital executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all providers with whom the hospital executes a subcontract.

L. If there is an insufficient number of, or an inadequate member capacity in, contracts awarded to prepaid capitated providers, the director, in order to deliver covered services to members enrolled or expected to be enrolled in the system within a county, may negotiate and award, without bid, a prepaid capitated contract with a health care services organization holding a certificate of authority pursuant to title 20, chapter 4, article 9. The director shall require a health care services organization contracting under this subsection to comply with section 36-2906.01. The term of the contract shall not extend beyond the next bid and contract award process as provided in section 36-2906 and shall be no greater than capitation rates paid to prepaid capitated providers in the same county or counties pursuant to section 36-2906. Contracts awarded pursuant to this subsection are exempt from the requirements of title 41, chapter 23.

M. A prepaid capitated provider may require that subcontracting providers or nonproviders shall be paid for covered services, other than hospital services, according to the capped fee-for-service schedule adopted by the director pursuant to subsection A, paragraph 2 of this section or subsection B, paragraph 1 of this section or at lower rates as may be negotiated by the prepaid capitated provider.

N. The director shall require any prepaid capitated provider to have a plan to notify members of reproductive age either directly or through the parent or legal guardian, whichever is most appropriate, of the specific covered family planning services available to them and a plan to deliver those services to members who request them. The director shall ensure that these plans include provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

O. The director shall adopt a plan to notify members of reproductive age who receive care from a prepaid capitated provider who elects not to provide family planning services of the specific covered family planning services available to them and to provide for the delivery of those services to members who request them. Notification may be directly to the member, or

through the parent or legal guardian, whichever is most appropriate. The director shall ensure that the plan includes provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

P. The director shall annually prepare a report representing a statistically valid sample which indicates the number of children ages two and under by prepaid capitated provider who received the immunizations recommended by the national centers for disease control and prevention while enrolled as members. The report shall indicate each type of immunization and the number and percentage of enrolled children ages two and under who received each type of immunization. The report shall be done by contract year and shall be delivered to the governor, the president of the senate and the speaker of the house of representatives no later than ~~January 30~~ APRIL 1 of each year.

Q. If the administration implements an electronic claims submission system it may adopt procedures pursuant to subsection K, paragraph 1 of this section requiring documentation different than prescribed under subsection K, paragraph 1, subdivision (d) of this section.

APPROVED BY THE GOVERNOR APRIL 3, 2001.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 3, 2001.

Passed the House March 27, 2001,

by the following vote: 59 Ayes,

0 Nays, 1 Not Voting

Speaker of the House

Norman L. Moore
Chief Clerk of the House

Passed the Senate February 14, 2001,

by the following vote: 30 Ayes,

0 Nays, 0 Not Voting

President of the Senate

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR
This Bill was received by the Governor this

28 day of March, 2001,

at 11:40 o'clock A M.

Stacy Marshall
Secretary to the Governor

Approved this 3 day of

April, 2001,

at 2:30 o'clock P M.

Governor of Arizona

S.B. 1141

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 3 day of April, 2001,

at 3:45 o'clock P M.

Secretary of State